

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028696

Facility Name: BIRCHWOOD PLAZA

Address: 1426 W BIRCHWOOD CHICAGO 60626
Number City Zip Code

County: COOK

Telephone Number: (773) 274-4405 Fax # (773) 274-4763

IDPA ID Number: 36-330652201

Date of Initial License for Current Owners: 06/17/84

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 01/01/2001 to 12/31/2001
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) CHARLOTTE KOHN
(Title) EXECUTIVE DIRECTOR

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BIRCHWOOD PLAZA

0028696 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 6/28/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>192</u>	Skilled (SNF)	<u>192</u>	<u>70,080</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>192</u>	TOTALS	<u>192</u>	<u>70,080</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>40,100</u>	<u>10,188</u>	<u>2,031</u>	<u>52,319</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>40,100</u>	<u>10,188</u>	<u>2,031</u>	<u>52,319</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.66%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/17/84

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/17/84 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 29 and days of care provided 2,031

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	182,201	26,707	7,852	216,760		216,760	0	216,760			1
2	Food Purchase		197,381		197,381	(16,790)	180,591	(715)	179,876			2
3	Housekeeping	153,169	29,144	0	182,313		182,313	0	182,313			3
4	Laundry	39,973	12,270	2,704	54,947		54,947	0	54,947			4
5	Heat and Other Utilities			111,313	111,313		111,313	0	111,313			5
6	Maintenance	63,047	26,454	19,850	109,351		109,351	4,031	113,382			6
7	Other (specify):*			4,734	4,734		4,734	0	4,734			7
8	TOTAL General Services	438,390	291,956	146,453	876,799	(16,790)	860,009	3,316	863,325			8
	B. Health Care and Programs											
9	Medical Director	0		6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	1,369,414	38,580	49,203	1,457,197		1,457,197	0	1,457,197			10
10a	Therapy	68,943		46,046	114,989		114,989	0	114,989			10a
11	Activities	99,246	15,865	4,080	119,191		119,191	0	119,191			11
12	Social Services	69,296		2,400	71,696		71,696	0	71,696			12
13	Nurse Aide Training			10,718	10,718		10,718	0	10,718			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	1,606,899	54,445	118,447	1,779,791	0	1,779,791	0	1,779,791			16
	C. General Administration											
17	Administrative	192,399		364,323	556,722		556,722	0	556,722			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			81,647	81,647		81,647	0	81,647			19
20	Dues, Fees, Subscriptions & Promotions			36,775	36,775		36,775	(30,544)	6,231			20
21	Clerical & General Office Expenses	120,837	8,695	34,727	164,259		164,259	(106)	164,153			21
22	Employee Benefits & Payroll Taxes			342,847	342,847	16,790	359,637	0	359,637			22
23	Inservice Training & Education			1,164	1,164		1,164	0	1,164			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			3,582	3,582		3,582	(100)	3,482			25
26	Insurance-Prop.Liab.Malpractice			304,799	304,799		304,799	0	304,799			26
27	Other (specify):*			0	0		0	0	0			27
28	TOTAL General Administration	313,236	8,695	1,169,864	1,491,795	16,790	1,508,585	(30,750)	1,477,835			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,358,525	355,096	1,434,764	4,148,385	0	4,148,385	(27,434)	4,120,951			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation				0		0	129,777	129,777			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	59,860	59,860			32
33	Real Estate Taxes			135,884	135,884		135,884	0	135,884			33
34	Rent-Facility & Grounds			421,904	421,904		421,904	(421,904)	0			34
35	Rent-Equipment & Vehicles			26,727	26,727		26,727	0	26,727			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			584,515	584,515	0	584,515	(232,267)	352,248			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		66,321	16,493	82,814		82,814	0	82,814			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			105,120	105,120		105,120	0	105,120			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	66,321	121,613	187,934	0	187,934	0	187,934			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,358,525	421,417	2,140,892	4,920,834	0	4,920,834	(259,701)	4,661,133			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(715)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(100)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(121)	21		18
19	Entertainment				19
20	Contributions	(775)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,149)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(22,620)	20		28
29	Other-Attach Schedule SEE PAGE 5A	4,031			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,449)		\$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(232,252)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (232,252)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (259,701)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 4,031	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	4,031		49

Summary A

12/31/2001

[illegible]

Summary B

12/31/2001

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CHARLOTTE KOHN	55.7	DOBSON PLAZA INC	EVANSTON	BIRCHWOOD PLAZA ASSOCIATES		REAL ESTATE
		PEDIATRIC REHABILITATION INSTITUTE	CHICAGO		CHICAGO	RENTAL

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	RENT	\$ 421,904	BIRCHWOOD PLAZA ASSOCIATES		\$	(421,904)	1
2	V	30	SL DEPRECIATION		" "		129,777	129,777	2
3	V	32	INTEREST		" "		59,860	59,860	3
4	V	21	OFFICE EXPENSE		" "		15	15	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 421,904			\$ 189,652	\$ * (232,252)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN	PRESIDENT	EXEC DIR.	100.00	362,571	30	40.00	MGMT FEES	\$ 364,323	17-3	1
2	RAMONA WEINGARTEN	DAUGHTER	ACTIVITIES			40	100.00	SALARY	30,778	11-1	2
3	ASHER KOHN	SON	MAINTENANCE		89,860	1	2.00	SALARY	1,887	6-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 396,988		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	RELATED PARTY - BIRCHWOOD PLAZA ASSOCIATES:						\$				\$	1		
2	MID-NORTH FINANCIAL		X	MORTGAGE	\$46,440.00	1/6/1994		2,000,000	527,569	1/04	7.5	49,250	2	
3	TITLE & LOAN FEES		X	AMORTIZED OVER 10 YRS				106,103	19,535			10,610	3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related				\$46,440.00		\$	2,106,103	\$	547,104		\$	59,860	9
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	0	14
15	TOTALS (line 9+line14)						\$	2,106,103	\$	547,104		\$	59,860	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>			
1. Real Estate Tax accrual used on 2000 report.	\$	194,250	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	164,244	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(30,006)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	165,890	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	135,884	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996	192,413	8
1997	190,211	9
1998	193,588	10
1999	192,289	11
2000	164,244	12

FROM RELATED PARTY: BIRCHWOOD PLAZA ASSOC

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED

ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 11-29-302-011-0000	NURSING HOME	\$ 2,841.30	\$ 2,841.30
2. 11-29-302-012-0000	NURSING HOME	\$ 71,651.47	\$ 71,651.47
3. 11-29-302-020-0000	NURSING HOME	\$ 89,751.33	\$ 89,751.33
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 164,244.10	\$ 164,244.10

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior BRICK Frame STEEL & CONCRET Number of Stories

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	RELATED PARTY: BIRCHWOOD PLAZA ASSOC			\$	1
2	NURSING HOME		1984	80,569	2
3	TOTALS			\$ 80,569	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: BIRCHWOOD PLAZA ASSOC				\$	\$		\$	\$	\$	4
5	192		1984		2,238,672	89,304	40	55,967	(33,337)	1,017,424	5
6											6
7											7
8											8
	Improvement Type**										
9	CONCRETE PAVING & RAILS			1984	13,495	577	20	675	98	11,614	9
10	SPRINKLER MODIFICATION			1984	2,752	110	25	110		1,920	10
11	LOBBY RENOVATION			1984	2,489	62	40	62		1,102	11
12	TERRACE RESURFACE			1984	7,600	304	15		(304)	7,600	12
13	FOYER RE-FLOORING			1984	1,835	73	20	92	19	1,568	13
14	BASEMENT RENOVATION			1985	18,061	721	40	452	(269)	8,095	14
15	NURSING STATION REMODELLING			1985	7,755	310	20	388	78	6,531	15
16	ASPHALT ROOF			1985	7,000		15			7,000	16
17	NURSE CALL SYSTEM REWIRE			1985	4,066		15			4,066	17
18	SPRINKLER MODIFICATION			1985	2,963	119	25	119		1,920	18
19	BASEMENT AWNINGS			1985	1,620	63	15	9	(54)	1,620	19
20	GRAVEL ROOF			1985	2,700	0	5	0		2,700	20
21	CEILING BASEMENT NURSING OFFICE			1985	1,200	60	20	60		965	21
22	ELEVATOR OVERHAUL			1985	12,800	641	20	640	(1)	10,308	22
23	VARIOUS (ELECTRIC & SPRINKLER)			1986	5,486	230	20	274	44	4,340	23
24	ELECTRIC PANEL			1988	6,000	191	20	300	109	3,940	24
25	ELECTRICAL IMPROVEMENTS			1990	1,200	38	20	60	22	678	25
26	ELEVATOR IMPROVEMENTS			1990	15,600	495	20	780	285	8,945	26
27	TUCKPOINTING & BRICKWORK			1990	12,300	391	20	615	224	6,592	27
28	LAUNDRY ROOM DUCTWORK			1990	3,000	95	20	150	55	1,620	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR			1994	282,054	7,336	20	14,103	6,767	106,663	29
30	DRAPERY			1994	7,933	0	5	1,587	1,587	11,109	30
31	ROOF & PARKING LOT IMPROVEMENTS			1995	69,984	1,992	15	4,666	2,674	28,425	31
32	ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)			1997	0	149	39	149		521	32
33	WINDOWS			1998	41,775	615	25	1,671	1,056	6,684	33
34	SIDING			1998	20,000	513	25	800	287	3,200	34
35	PATIENT ROOM EXHAUST SYSTEM			1998	9,720	486	20	486		1,539	35
36	ELEVATOR SAFETY DEVICES			1998	5,350	357	15	357		1,190	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING EXTENSION (1994) ALLOWED FOR 1998	1998	\$ 49,866	\$ 0	20	\$ 2,493	\$ 2,493	\$ 9,972	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		3,772	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPE	1999	27,264	699	39	699		1,748	39
40	CARPETING / DRAPERIES	2000	5,062	1,240	7	723	(517)	1,085	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		378	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	117	27.5	117		117	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	2,028	27.5	2,028		2,028	43
44	DRAPERIES / CARPETING	2001	8,264	1,653	7	590	(1,063)	590	44
45									45
46									46
47									47
48	ADJ TO SL			(19,747)			19,747		48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,055,513	\$ 92,964		\$ 92,964	\$ 0	\$ 1,289,569	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 348,604	\$ 34,716	\$ 34,716	\$ 0	5 - 15 YRS	\$ 257,766	71
72	Current Year Purchases	11,477	642	642	0		642	72
73	Fully Depreciated Assets	279,548			0		279,548	73
74	FROM XI-B (97 AUDIT)	14,550	1,455	1,455	0	10 YRS	5,820	74
75	TOTALS	\$ 654,179	\$ 36,813	\$ 36,813	\$ 0		\$ 543,776	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,790,261	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 129,777	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 129,777	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,833,345	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: X YES NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN,BANKING, /	'01 LEXUS RX300	\$ 815.15	\$ 9,196	17
18	PURCHASING,	99 MAXIMA	342.50	4,127	18
19	MAINT,ETC	'98 MITSUBISHI	826.97	9,924	19
20	\	'98 FORD WINDSTAR VAN	290.00	3,480	20
21	TOTAL		\$ 2,274.62	\$ 26,727	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		12		3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$ 0
2	Books and Supplies		218		218
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments		10,500		10,500
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 10,718	\$ 0	\$ 10,718
10	SUM OF line 9, col. 1 and 2 (e)	\$ 10,718			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					hrs	\$		\$	\$	
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist	39-3	hrs			774			774	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			15,719			15,719	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				44,516		44,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): SUPPLIES	39-2					21,805		21,805	13
14	TOTAL			\$		\$ 16,493	\$ 66,321		\$ 82,814	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 388,751	\$ 409,816	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,022,309	1,022,309	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	189,245	189,245	6
7	Other Prepaid Expenses	71,817	71,817	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX ESCROW</u>		140,776	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,672,122	\$ 1,833,963	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		80,569	13
14	Buildings, at Historical Cost		2,232,597	14
15	Leasehold Improvements, at Historical Cost		784,356	15
16	Equipment, at Historical Cost		653,228	16
17	Accumulated Depreciation (book methods)		(2,986,585)	17
18	Deferred Charges	18,484	38,019	18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 18,484	\$ 802,184	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,690,606	\$ 2,636,147	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 218,623	\$ 218,623	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,488	62,488	28
29	Short-Term Notes Payable	120,812	120,812	29
30	Accrued Salaries Payable	130,045	130,045	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	54,002	54,002	31
32	Accrued Real Estate Taxes(Sch.IX-B)		165,890	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DEFERRED INCOME</u>	111,263	111,263	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 697,233	\$ 863,123	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		527,569	40
41	Bonds Payable			41
42	Deferred Compensation	12,252	12,252	42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO BP ASSOC</u>	1,181,667	0	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,193,919	\$ 539,821	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,891,152	\$ 1,402,944	46
47	TOTAL EQUITY(page 18, line 24)	\$ (200,546)	\$ 1,233,203	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,690,606	\$ 2,636,147	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (535,773)	1
2	Restatements (describe):		2
3	2000 IL REPLACEMENT TAX	(20,300)	3
4	ROUNDING	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (556,076)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,419,366	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,063,836)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 355,530	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (200,546)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BIRCHWOOD PLAZA** # **0028696** Report Period Beginning: **01/01/2001** Ending: **12/31/2001**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,114,265	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,114,265	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,643	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 15,643	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	249	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	62,983	21
22	Laundry	7,435	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 70,667	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,625	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,625	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	131,000	27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 131,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,340,200	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	876,799	31
32	Health Care	1,779,791	32
33	General Administration	1,491,795	33
	B. Capital Expense		
34	Ownership	584,515	34
	C. Ancillary Expense		
35	Special Cost Centers	82,814	35
36	Provider Participation Fee	105,120	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,920,834	40
41	Income before Income Taxes (line 30 minus line 40)**	1,419,366	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,419,366	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,953	4,580	\$ 131,304	\$ 28.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,505	21,993	499,588	22.72	3
4	Licensed Practical Nurses	7,827	8,723	148,787	17.06	4
5	Nurse Aides & Orderlies	58,975	64,301	589,735	9.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,715	5,612	68,943	12.28	8
9	Activity Director					9
10	Activity Assistants	10,369	10,967	99,246	9.05	10
11	Social Service Workers	4,160	4,946	69,296	14.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,013	2,329	34,875	14.97	14
15	Cook Helpers/Assistants	3,483	4,044	36,366	8.99	15
16	Dishwashers	12,627	14,014	110,960	7.92	16
17	Maintenance Workers	8,008	8,903	63,047	7.08	17
18	Housekeepers	17,151	19,220	153,169	7.97	18
19	Laundry	6,092	6,484	39,973	6.16	19
20	Administrator	1,920	2,958	175,771	59.42	20
21	Assistant Administrator	2,080	2,299	16,628	7.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,705	10,438	120,837	11.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,583	191,811	\$ 2,358,525 *	\$ 12.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 7,852	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	4,032	10-3	37
38	Nurse Consultant	T	6,006	10-3	38
39	Pharmacist Consultant	H	1,350	10-3	39
40	Physical Therapy Consultant	L	7,596	10a-3	40
41	Occupational Therapy Consultant	Y	38,450	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,400	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 73,686		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,422	\$ 32,001		50
51	Licensed Practical Nurses				51
52	Nurse Aides	56	532		52
53	TOTAL (lines 50 - 52)	1,478	\$ 32,533		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
ABRAHAM SCHIFFMAN	ADMIN	0.00%	\$ 175,771	Workers' Compensation Insurance		\$ 28,397	IDPH License Fee	\$ 200
JOYCE GRODETZ	ASST ADMIN	0.00%	16,628	Unemployment Compensation Insurance		10,848	Advertising: Employee Recruitment	1,026
				FICA Taxes		175,094	Health Care Worker Background Check	750
				Employee Health Insurance		107,973	(Indicate # of checks performed 63)	
				Employee Meals		16,790	MARKETING/ADV/PROMO	29,769
				Illinois Municipal Retirement Fund (IMRF)*			TRUST FEES/CONTRIBUTIONS/ETC	775
				EMPLOYEE BENEFITS - OTHER		4,547	LICENSES & PERMITS	3,624
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	631
				PENSION/PROFIT SHARING PLANS		11,704		
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		4,284	TRUST FEES/CONTRIBUTIONS/ETC	(775)
(List each licensed administrator separately.)			\$ 192,399	INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(7,149)
Description			Amount				Yellow page advertising	(22,620)
CHARLOTTE KOHN	MANAGEMENT FEES		\$ 364,323					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 364,323	TOTAL (agree to Schedule V, line 22, col.8)		\$ 359,637	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,231
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
SEE ATTACHED			81,647				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 81,647				TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	SPRINKLER BOX	1998	\$2,404	3	\$267	\$801	\$801	\$535	\$	\$	\$	\$	\$
2	TILE REPLACEMENT	1998	4,000	3	417	1,000	1,000	1,000	583				
3	PAINT/DECORATING	1999	12,840	3		2,140	4,280	4,280	2,140				
4	PAINT/DECORATING	2000	2,746	3			458	915	915	458			
5	PAINT/DECORATING	2001	3,239	3				540	1,080	1,080	539		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$25,229		\$684	\$3,941	\$6,539	\$7,270	\$4,718	\$1,538	\$539	\$	\$

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 105,120
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 16,790 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,852
	REPAIRS & MAINTENANCE	0
		0
		7,852
3	HOUSEKEEPING	
		0
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,704
		0
		2,704
5	HEAT & OTHER UTILITIES	
	GAS HEAT	52,184
	ELECTRICITY	49,188
	WATER	9,941
	CABLE TV - LOBBY	0
		0
		111,313
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,106
	PAINTING & DECORATING	3,239
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,017
	ELEVATOR MAINTENANCE & REPAIR	4,128
	OUTSIDE LABOR	1,087
	EXTERMINATING SERVICE	2,700
	FIRE SERVICE	1,573
		0
		0
		0
		19,850
7	OTHER	
	SCAVENGER	4,734
	SECURITY SERVICE	0
		4,734
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	32,533
	LABORATORY & XRAY EXPENSE	5,282
	DENTAL SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,032
	PHARMACY CONSULTANT XVIII B 39-2	1,350
	UTILIZATION REVIEW FEES XVIII B __-2	0
	NEUROLOGIST XVIII B __-2	0
	MR/DD CONSULTANT XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	6,006
		0
		0
		49,203
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	THERAPY CONTRACT SERVICES	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	7,596
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	38,450
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		46,046
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	4,080
		4,080
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,400
		0
		2,400
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	10,718
		10,718

V.COST CENTER EXPENSES			PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL		
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION	0	0	
17	ADMINISTRATIVE			
	MANAGEMENT FEES XIX B	364,323	364,323	
18	DIRECTORS FEES	0	0	
19	PROFESSIONAL SERVICES			
	DATA PROCESSING XIX C	5,222		
	ADMINISTRATIVE CONSULTANTS XIX C	0		
	PROFESSIONAL FEES XIX C	76,425		
		0	81,647	
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING VI 19 XIX F	0		
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,149		
	EMPLOYEE WANT ADS XIX F	1,026		
	CONTRIBUTIONS VI 20 XIX F	275		
	DUES & SUBSCRIPTIONS XIX F	631		
	LICENSES & PERMITS XIX F	3,824		
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0		
	ADVERTISING-YELLOW PAGES VI 28 XIX F	22,620		
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0		
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500		
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	750	36,775	
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES	19		
	EQUIPMENT REPAIR & MAINTENANCE	4,450		
	OUTSIDE CLERICAL SERVICES	0		
	PENALTIES / OVERDRAFT CHARGES VI 18	121		
	HOME OFFICE EXPENSE	0		
	THEFT & DAMAGE LOSS	0		
	TELEPHONE	30,137		
	MESSENGER SERVICE	0		
		0	34,727	

LINE	SCHED REF	TOTAL		
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES XIX D	175,094		
	UNEMPLOYMENT COMPENSATION XIX D	10,848		
	WORKERS COMPENSATION INSURANC XIX D	28,397		
	HOSPITALIZATION INSURANCE XIX D	107,973		
	EMPLOYEE BENEFITS - OTHER XIX D	4,547		
	EMPLOYEE PHYSICAL EXAMS XIX D	0		
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0		
	PENSION/PROFIT SHARING PLANS XIX D	11,704		
	CHICAGO HEAD TAX XIX D	4,284	342,847	
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS	1,164	1,164	
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS XIX G	0		
	TRAVEL XIX G			
		0		
		0	0	
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF	3,582	3,582	
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE	304,799	304,799	
27	OTHER			
	BAD DEBTS VI 24	0		
		0	0	

GRAND TOTAL COLUMN 3 OTHER

1,434,764

BIRCHWOOD PLAZA
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	197,381	PATIENT MEALS	156957
LESS SALES TAX	(715)	ADD EMPLOYEE MEALS	14600
	-----		-----
NET FOOD	196,666	TOTAL MEALS/YEAR	171557
TOTAL PATIENT CENSUS	52,319	NET FOOD	196666
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	171557

TOTAL PATIENT MEALS	156957	COST PER MEAL	1.15
		TIME EMPLOYEE MEALS	14600
ADD # EMPLOYEE MEALS/DAY	40		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	16790
	-----		=====
TOTAL EMPLOYEE MEALS	14600		